STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING 01 B. WING	01/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000				
	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/27/12 Facility Number: 000038 Provider Number: 155095 AIM Number: 100274830 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Heritage Park was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully	K0000	The creation and submission of the Plan of Correction does not constitute an admission by this providerof any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be consideredthe Letter of Credible Allegation.The facility requests a post survey revisit on or before 2/20/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and only the resident rooms on the 200 hall. The remaining resident rooms do not have smoke detectors. The facility has a capacity of 180 and had a census of 172 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/31/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by			

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K0014 SS=E	Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2			
	Based on observation and interview, the facility failed to provide documentation for the flame spread rating of interior finish materials installed within exit access for 3 of 9 corridors the facility. This deficient practice could affect all occupants in the 700, 800, and 900 halls. Findings include: Based on observations with the Maintenance Supervisor on 01/27/12 during the tour from 12:45 p.m. to 1:10 p.m., carpet was installed on the bottom one third of the corridor walls in the 700, 800 and 900 halls. Based on an interview with the Maintenance Supervisor at the time of observations, no documentation was available to demonstrate the carpet provides a flame spread rating of Class A or Class B. 3.1-19(b)	K0014	1. No residents were found to be affected by the alleged deficient practice. Areas have been treated to provide a flame spread rating of Class A or B2. All residents residing on 700, 800 and 900 halls had the potential to be affected by the alleged deficient practice.3. We are no longer installing carpeting on walls. As we remodel the building we will obtain appropriate flame spread ratings from our vendors for interior finish surfaces.4. Vendors will be required to provide flame spread rating information at the time the work begins, if unable to do so, the Executive Director or designee will not allow the work to continue. Executive Director/Designee will visualize flame spread ratings where needed by regulation, before remodel work begins. A file of flame spread ratings will be maintained in the facility. The CQI team will review this file, quaterly for compliance, on-going.	02/20/2012

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K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure the door protecting corridor opening for 1 of 1 Social Service offices was smoke resistive. This deficient practice could affect any resident near the Social Service door in the event of an emergency. Findings include: Based on an observation with the Maintenance Supervisor on 01/27/12 at 1:25 p.m., the corridor door to the Social Service office was a Dutch type door. There was an one half inch gap between the upper and lower halves of the door. Measurements were provided by the Maintenance	K0018	1. No residents were found to be affected by the alleged deficient practice. Doors indicated in the survey have been replaced with solid doors to provide a smoke resistant barrier.2. All residents in the area of the Social Service office had the potential to be affected by the alleged deficient practice.3. No purchase orders will be approved for the purchase of "dutch" doors. 4. Executive Director reviews all purchase orders prior to purchases being made. Purchase orders are also reviewed monthly by managers-on-going.	02/20/2012

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	Supervisor at the time of observation. 3.1-19(b)			

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1			
	Based on observation and interview, the facility failed to ensure the 1 of 2 corridor doors to the kitchen, a hazardous area, was provided with latching hardware and latched into the door frame. This deficient practice could affect any resident in the main dining room. Findings include: Based on observation with the Maintenance Supervisor on 01/27/12 at 12:35 p.m., the main dining room was open to the corridor and met the requirements for a space to be allowed to be open to the corridor. The wall around the dining room is therefore considered to be the corridor wall. The door entering the kitchen near the pass through window lacked latching hardware	K0029	1. No residents were found to be affected by the alleged deficient practice. The dietary door indicated in the survey has been replaced with a door with latching hardware and which latches into the door frame.2. Residents in thea area of the main dining room had the potential to be affected by this alleged deficient practice.3. Executive Director approves all purchase order prior to purchases being made.4. Executive Director reviews all purchase orders prior to purchase being made. Purhase order are are reviewed monthly with managers, on-going.	02/20/2012

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	and did not latch into the door frame. This was confirmed by the Maintenance Supervisor at the time of observation. 3.1-19(b)			

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K0051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6			
	Based on observation and interview, the facility failed to ensure 1 of 2 fire alarm control panels located in an area not continuously occupied, was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.2.10 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in	K0051	1. No residents were found to be affected by the alleged deficient practice. A automatic smoke detector has been installed where the alarm control panel phone dialer is located.2. All residents had the potential to be affected by the alleged deficient practice. 3. This issue has been corrected. If there are physical plant changes, the Executive Director will review all plans prior to implementation.4. Executive Director will review all new plans, if changes should become necessary and will review with CQI, prior to any change, on-going.	02/20/2012

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	that location. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observation with the Maintenance Supervisor on 01/27/12 at 1:50 p.m., the fire alarm control panel phone dialer was located in the electrical room behind the kitchen and was not electrically supervised by a smoke detector. This was acknowledged by the Maintenance Supervisor at the time of observation. 3-1.19(b)			

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K0056 SS=F	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 sprinkler riser rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect all occupants. Findings include: Based on an observation with the Maintenance Supervisor on 01/27/12 at 11:00 a.m., the sprinkler riser room lacked sprinkler coverage. This was confirmed by the Maintenance Supervisor at the time of	K0056	1. No residents were found to be affected by the alleged deficient practice. Sprinkler has been installed in the sprinkler riser room. Sprinkler head in dietary has been relocated to meet the standard. Sprinkler head has been installed under the canopy identified in the deficiency.2. All residents in the areas identified had the potential to be affected by the alleged deficient practice.3. These alleged issues had never been identified in any prior life safety survey. The Executive Director will assure there are no reoccurences by review of any physical plant changes related to sprinklers.4. Executive Director will review as indicated in #3. CQI will review any physcial plant changes related to sprinklers prior to implementation, on-going.	02/20/2012

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	observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 9 sprinkler heads in the kitchen dish room were separated by at least six feet as required by NFPA 13. NFPA 13, Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect all kitchen staff and any resident in the main dining room. Findings include: Based on an observation with the Maintenance Supervisor on 01/27/12 at 12:30 p.m., two sprinkler heads near the dish machine in the kitchen dish room were mounted sixty three inches apart. Measurements were provided by the Maintenance Supervisor at the time of observation. 3.1-19(b) 3. Based on observation and			

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	interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 4 building canopies in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13-1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect any resident evacuated through the Rehabilitation entrance # 3 in the event of an emergency. Findings include: Based on an observation with the Maintenance Supervisor on 01/27/12 at 1:05 p.m., the Rehabilitation entrance # 3 had an unsprinklered combustible overhang made of wood frame construction extending fifty six inches from the building. Measurements were provided by the Maintenance Supervisor at the time of observation. 3.1-19(b)			

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